



DWS-FA  
Form 275 3\99

**Department of Workforce Services**  
**REQUEST FOR VERIFICATION OF**  
**DEPARTMENT OF VETERAN'S ADMINISTRATION BENEFIT PAYMENT**

Date: \_\_\_\_\_

Dear Veteran's Administration Representative:

The individual named below is now applying for or receiving Medicaid Assistance and/or Public Assistance. To establish his/her eligibility or continuing eligibility, it is necessary that the amount of his/her Veteran's pension, compensation, or apportionment to his/her dependents be verified.

It is requested that you furnish this information to the Utah Department of Workforce Services. THIS INFORMATION WILL BE USED ONLY FOR THE PURPOSE STATED AND WILL NOT BE DISCLOSED TO ANY OTHER ORGANIZATION OR INDIVIDUAL.

\_\_\_\_\_  
DWS Representative Signature

\_\_\_\_\_  
Job Title

VETERAN: Name \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Claim or Service No. \_\_\_\_\_

RECIPIENT: Name \_\_\_\_\_  
Social Security No. \_\_\_\_\_

REMARKS OR OTHER REQUESTS: \_\_\_\_\_

PLEASE VERIFY THE VETERAN'S INCOME AND BENEFITS FOR THE ABOVE NAMED INDIVIDUAL:

	VETERAN	SPOUSE
PRESENT TOTAL MONTHLY BENEFIT	\$ _____	\$ _____
DIVIDED AS FOLLOWS:		
Monthly Maximum Pension	_____	_____
Aid and Attendance	_____	_____
Life Insurance Premium	_____	_____
Overpayment Withheld	_____	_____
Education Benefits	_____	_____
Other _____	_____	_____
Other dependents included in benefit and amount:		
Name _____ SS# _____		\$ _____
_____	_____	_____
_____	_____	_____

EFFECTIVE DATE BENEFIT PAYMENT BEGAN?  
EFFECTIVE DATE OF NEXT BENEFIT CHANGE?  
DATE OVERPAYMENT WILL END?

**LIFE INSURANCE:**

Total Current Death Benefit \$ \_\_\_\_\_ Guaranteed Cash Value \$ \_\_\_\_\_  
Net Loan Value Available \_\_\_\_\_ Cash Value of Dividends \_\_\_\_\_  
Combined Surrender Value \_\_\_\_\_  
Are dividends or interest earned, paid/accrued? \_\_\_\_\_ \$ \_\_\_\_\_  
Date paid or accrued? \_\_\_\_\_ Do they have other policies? ☐ Yes ☐ No

\_\_\_\_\_  
Signature of Veterans Administration Representative

\_\_\_\_\_  
Date